Welcome to Dr. Peer's Office **New Patient Registration Form**

Patient Name: [ ] Last [ ] First [ ] MI [ ] Preferred Name

Title: [ ] Mr/Mrs/Ms/etc **Gender:** [ ] Male [ ] Female **Family Status:** [ ] Married [ ] Single [ ] Child [ ] Other

Birth Date: [ ] **Social Security #** [ ] **Previous Visit Date** [ ]

Email Address: [ ] **Best time to call:** [ ]

Phone: [ ] Home [ ] Work [ ] ext. [ ] Mobile (Cell) [ ] Fax [ ] Other

Address:

How did you hear about us?

In an emergency who should be notified? Please enter Name and Phone Number below:

Employment Information

The following is for: [ ] the patient [ ] the person responsible for payment

Employer Name: **Phone:**

Address:

Primary Dental Insurance

Name of Insured: ______ (Last) ______ (First) ______ (MI)

Insured's Birth Date: ______ **ID #:** ______ **Group #:** ______

Insured's Address: ______

Insured's Employer Name: ______

Employer's Address: ______

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: ______

Insurance Address: ______

Insurance Company Phone Number: ______

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient Signature: ____ **Date:** ____________________

Dental Information

How would you rate the condition of your mouth?

☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

Previous Dentist's Name and Phone Number:

Date of most recent dental exam and dental x-rays:

I routinely see my dentist every:

☐ **3 months** ☐ **4 months** ☐ **6 months** ☐ **12 months** ☐ **Not routinely**

What is your immediate concern?

Is there anything about the appearance of your smile that you would like to change?

Check all that apply:

- ☐ **Had complications from past dental treatment**
- ☐ **Had trouble getting numb**
- ☐ **Had any reactions to local anesthetic**
- ☐ **Had/have braces, orthodontic treatment**
- ☐ **You experience dry mouth**
- ☐ **Any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth**
- ☐ **Food gets trapped between any teeth**
- ☐ **Have you ever whitened or bleached your teeth**
- ☐ **Have you experienced popping and/or clicking of your jaw joint**
- ☐ **You have difficulty chewing**
- ☐ **You clench or grind your teeth**
- ☐ **You wear or have worn a bite applianceOldhcps**
- ☐ **Gums bleed when brushing or flossing**
- ☐ **Treated for gum disease or were told you have lost bone around your teeth**
- ☐ **Noticed an unpleasant taste or odor in your mouth**
- ☐ **Experienced gum recession**
- ☐ **Had any teeth become loose on their own (without injury)**
- ☐ **Experienced a burning sensation in your mouth**
- ☐ **You snore or wake up frequently during the night**

If any of the checked boxes need further explanation, please describe:

Consent for Services and Financial Policy

Financial arrangements must be made in advance as a condition of treatment by this office. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients with dental insurance understand that all dental services are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms, assist in making collections from insurance companies, and will credit any collections to the patient's account. This dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. If after 60 days the bill has not been paid, we shall have the right to take any legal action needed to collect said bill through our collection agency. They shall have to the right to collect reasonable attorney fees equal to 25% of the total bill. I agree to pay the charges for the services at the time of treatment, or within 5 days of billing if credit is extended. I further agree that the charges for services shall be billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee to telephone me to discuss this statement or my treatment.

☐ **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.**

HIPPA Acknowledgement

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to: (1) provide/coordinate my treatment among health care providers who may be involved in that treatment directly/indirectly, (2) obtain payment from third-party payers for my health care services, and (3) conduct normal health care operations such as quality assessment and improvement activities. I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I understand that you are not required to agree to my requested restrictions, but, if you do agree, then you are bound to abide by such restrictions.

You may contact me at: (Please check all that apply)

☐ **My home telephone number** ☐ **My mobile telephone number** ☐ **My work telephone number**
☐ **My email** ☐ **Other**

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians: (example: John Doe 212-555-1212)

☐ **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPPA Disclosure Form.**

Name of person completing this form:

Relationship to the patient: **Response Date:**

Medical History:

Patient Name: [Last] [First] [MI]

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving the box blank will indicate a "NO" response.

- ☐ **Allergies**
- ☐ **Arthritis**
- ☐ **Asthma – hay fever**
- ☐ **Bleeds excessively**
- ☐ **Ceclor allergy**
- ☐ **Coumadin/Warfarin allergy**
- ☐ **Dialysis**
- ☐ **Emphysema**
- ☐ **Fainting – dizziness**
- ☐ **Head injuries**
- ☐ **Hepatitis – jaundice**
- ☐ **High cholesterol**
- ☐ **Kidney disease**
- ☐ **Liver disease**
- ☐ **Organ transplant**
- ☐ **Pregnancy**
- ☐ **Respiratory problems**
- ☐ **Sex. Trans. Disease (STD)**
- ☐ **Stroke**
- ☐ **Thyroid disease**
- ☐ **Ulcers**
- ☐ **Anemia**
- ☐ **Artificial joints**
- ☐ **Barbiturate allergy**
- ☐ **Cancer**
- ☐ **Chemotherapy**
- ☐ **Darvocet allergy**
- ☐ **Doxycycline allergy**
- ☐ **Epilepsy – seizures**
- ☐ **Food allergy**
- ☐ **Heart disease**
- ☐ **Herpes**
- ☐ **HIV – AIDS**
- ☐ **Latex allergy**
- ☐ **Mental disorders**
- ☐ **Penicillin allergy**
- ☐ **Pre-med**
- ☐ **Rheumatic fever**
- ☐ **Sinus problems**
- ☐ **Sulfa allergy**
- ☐ **Tuberculosis**
- ☐ **Z-Pack allergy**
- ☐ **Angina**
- ☐ **Aspirin – Ibuprofen**
- ☐ **Bee Sting allergy**
- ☐ **Cardiac pacemaker**
- ☐ **Codeine allergy**
- ☐ **Diabetes**
- ☐ **Drug dependency**
- ☐ **Erythromycin allergy**
- ☐ **Glaucoma**
- ☐ **Heart murmur**
- ☐ **High Blood Pressure**
- ☐ **Iodine allergy**
- ☐ **Leukemia**
- ☐ **Nervous disorders**
- ☐ **Polio**
- ☐ **Radiation treatment**
- ☐ **Sedative allergy**
- ☐ **Stomach problems**
- ☐ **Swollen ankles**
- ☐ **Tumors**

- ☐ **Local anesthetics allergy** *Carbocaine, Lidocaine, Marcaine, Novocaine, Septocaine*
- ☐ **Presently being treated for any other illness**
- ☐ **Taking dietary supplements**
- ☐ **A smoker or smoked previously**
- ☐ **Rubber products allergy**
- ☐ **Taking medication for weight control** *(ie fen-phen)*
- ☐ **Subject to frequent headaches**
- ☐ **Drink alcohol regularly**

☐ **Other allergies that are not listed above:** [ ]

If any conditions or alerts selected above need further clarification, please describe below, indicating serious illnesses, operations, or hospitalizations:

[ ]

Have you had open heart or heart valve replacement surgery? If so, please describe below. Please include any complications from procedure:

Have you had an orthopedic total joint replacement (hip, knee, elbow, finger). If so, please describe below. Please include any complications from procedure:

Have you ever been told by a physician or dentist that you need to be pre-medicated by an antibiotic before your dental visits? If yes, please explain.

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

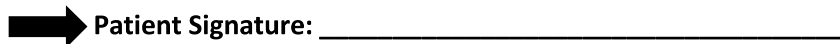
Name of your physician and date of your last physical:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications, drugs, pills or herbal remedies, regular dosages of aspirin, and non-prescription medications. Please include the problem for which each is taken.

Name of the pharmacy where you have your prescriptions filled:

☐ By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have been excluded. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.



Patient Signature: ______________________________ Date: ____________________

FEMALES ONLY:

- ☐ Taking contraceptives (birth control)
- ☐ Using Hormone Replacement Therapy
- ☐ Pregnant or planning pregnancy
- ☐ Nursing